Transforming the Public Health Service Commissioned Corps: CDC/ATSDR Perspective

Executive Summary

This paper provides an overview of the history of the USPHS Commissioned Corps' role specifically pertaining to applied public health functions at CDC. It explicates the unique characteristics and benefits of Commissioned Officers, and provides a vision of the Commissioned Corps' role in the future of the public's health in the 21st century.

Further, the paper outlines 22 recommendations to address ongoing issues that directly affect Commissioned Corps readiness and officer morale. For some recommendations, action can be taken directly by the agency. Others are meant to provide the Director, CDC/ATSDR, with talking points and issues of urgency to raise with the Secretary in her deliberations regarding the Corps at CDC/ATSDR.

Introduction/History

> *The President is deeply interested in the health activities of the Federal Government…Quite aside from the exacting standards set by the President there is reason for the Public Health Service to set its sights high. It stands at a critical point in its history. It will either take a leap forward, or it will become mired in its own internal conflicts and history will pass it by.(1)* ***John Gardner, Secretary of Department of Health, Education and Welfare, 1965***

The history of the Public Health Service and its Commissioned Corps of health professionals has been marked by several transformations. Secretary Gardner's comment – during a period of "self-renewal" of the Commissioned Corps in the mid-1960s – is applicable to current issues facing the Commissioned Corps. Department of Health and Human Services Secretary Tommy G. Thompson launched the most recent Commissioned Corps transformation with the support of President George W. Bush during the aftermath of the events of late 2001. Indeed, American society and government have been transformed and required all organizations at every level to examine their systems, processes, flexibility and responsiveness to novel threats. This contemporary period of self-renewal includes reorganization of most agencies within the Public Health Service and the Department of Health and Human Services.

Our nation needs the unique, diversified skills and expertise of the Public Health Service now more than ever. However, the current viability and utility of the Commissioned Corps have been questioned, generating considerable effort to transform and evolve the Commissioned Corps to meet these dynamic needs and priorities. Current efforts and proposed policies have focused on two areas: the ability to provide and maintain routine clinical services to underserved populations (particularly via the Indian Health Service) and the ability to provide urgent clinical response in emergency situations. Most notably, there has been a paucity of recognition for the necessity of public health expertise and contribution in crisis response.

While many Commissioned Officers assigned to duty at the traditionally recognized "public health agencies" – the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) – maintain clinical proficiency, all are assigned to non-clinical billets in support of the agency's applied public health mission. As such, CDC/ATSDR-assigned Commissioned Officers have questioned transformation efforts focused on clinical issues. Specifically they request reassurance that their work is fully understood and valued by the decision-makers leading the transformation efforts. This paper explores the modern evolution of public health in the United States and provides recommendations for a CDC/ATSDR action plan to 1) insure appropriate and reinvigorating transformation of the Commissioned Corps occurs, and 2) insure that its officer's unique skills and public health expertise are recognized, supported and valued in the context of a transformed Commissioned Corps.

What is Public Health?

In 1988, the Institute of Medicine (IOM) released its seminal report, the Future of Public Health(2). The IOM committee described the national public health infrastructure as "in disarray," and made specific recommendations to focus public health efforts. The IOM report

described the core public health functions as assessment of health status, policy development, and assurance that necessary services are provided. This report was complemented by a 1994 report of the Public Health Functions Workgroup of DHHS that described ten essential public health services corresponding to the IOM core functions.(3) The core functions and essential public health services were narrowly defined as the work of governmental public health organizations at the national, state, and local level and, thus, were important for refocusing public health organizations and individuals in an attempt to impose order on a system in disarray.

In 2003, the IOM revisited its 1988 report and released an updated version, "The Future of the Public's Health in the 21st Century" (4). This examination of public health in America expanded the definition of public health to include all of society's efforts to achieve improved health. Recommendations included all aspects of health policy at every level of American society and inaugurated a new era of enlisting all sectors of society in the goal of improving health outcomes.

This vision of public health permits synergy among the Public Health Service agencies and facilitates articulation of their common goals. The IOM recommendations should serve as a guide post for transforming the Public Health Service, especially the Commissioned Corps. To fully address the IOM recommendations, transformation should attend to all of the essential functions of the Public Health Service agencies – clinical, clinical, regulatory, applied public health, administration, research, and policy-making. The Public Health Service's various agencies have different responsibilities and emphasis on these diverse roles. For example, the Food and Drug Administration conducts research, regulatory, and policy-making functions. CDC/ATSDR focuses on applied public health, research, and policy making functions, but is specifically not authorized for regulatory functions barring some notable exceptions (e.g., quarantine).

CDC/ATSDR has the lead responsibility to provide applied public health functions within this broad definition of public health:

- Surveillance of health conditions, risk factors, environmental conditions
- Maintain the flow of public health information
- Provide health education
- Describe the natural history of health patterns
- Maintain national health statistics
- Mobilize non-Federal partners to combat chronic diseases, injuries, and infectious diseases
- Conduct or fund prevention research to create and test public health interventions for chronic diseases, injuries, and infectious diseases
- Fund the implementation of known effective public health interventions for chronic diseases, injuries and infectious diseases
- Provide quarantine and vessel sanitation services at ports of entry to the country
- Provide technical assistance to state and local health departments to support local public health activities
- Provide expertise, consulting and services globally

- Epidemiologic investigation of chronic diseases, injuries, risk factors, environmental issues
- Emergency response for infectious disease outbreaks and disasters (natural and man-made): epidemiologic investigation, control measures, rapid surveillance.
- Assess impact of outbreaks, emergencies, interventions.

The Unique Characteristics of Commissioned Officers

Commissioned Officers currently serve at staff, management, and leadership levels within every Public Health Service agency (including CDC/ATSDR) and in every functional role (i.e., clinical, regulatory, applied public health, administration, research, and policy-making). There are several unique attributes that serve to distinguish Commissioned Officers from their Civil Service colleagues (Table 1), and provide both direct and indirect benefits to CDC/ATSDR and the department (Table 2). Several of those characteristics and benefits are particularly important for CDC/ATSDR and merit detailed discussion.

1. Culture, History and Group Identity

   Commissioned Officers share a culture and history not found in the civil service. In his *Plagues and Politics: The Story of the United States Public Health Service*, Fitzhugh Mullen wrote, "For many, the Service was a culture, a way of life that entailed work, frequent moves, a far-flung camaraderie with other officers, and a quiet, perennial commitment to national service"(5). This sentiment endures as evidenced by the devotion of officers throughout the country who toil anonymously in hazardous, isolated, and uncredited jobs. And, while communication with other officers is far easier in the Information Age, camaraderie between all PHS officers is strengthened by virtue of rank, structure, and allegiance to ideals rather than organizations.

   Commissioned Officers share a group identity that crosses agency organizational lines that is rare among civil servants. Commissioned Officers are called upon to serve on Professional Advisory Committees, awards and promotion boards, and assimilation boards; provide mentoring and recruitment; participate in Corps-wide ceremonies; participate in leadership roles of the Commissioned Officers Association; and other "officership" activities. By their very nature, these activities generate an *esprit de corps* that transcends agency boundaries, solidifies cultural norms, and establishes recognition of rank and structure.

2. Visibility

   Uniformed Commissioned Officers are immediately identifiable to coworkers and the public. This visible expression of commitment and loyalty to a set of ideals and principles summarized by the sworn oath taken by each Commissioned Officer physically sets them apart from their civil service colleagues. This uniformed visibility can also be a source of reassurance to U.S. citizens. The uniform provides for immediate recognition of a trained cadre of health professionals, who provide assistance to the public.

3. Personnel Diversity and Flexibility

   There are several unique attributes that Commissioned Officers possess which permit greater flexibility and skill diversity. Promotion is partly based on programmatic and geographic assignment flexibility. These flexible assignments ultimately broaden a Commissioned Officer's knowledge base, develop new skill sets and develop communication skills enriching our officers' proficiency in varied short-term (e.g., deployment) and long-term settings. This directly and indirectly benefits the Agency where the Officer is assigned since they bring those skills and that knowledge with them. Commissioned Officers are also able to serve in higher levels of responsibility than what is commensurate with their current rank (in distinction to their civil service counterparts), which permits efficient management of capable personnel. In general, Officers must be serving in a level of responsibility that is higher than their current rank before promotion to that rank can be even considered. Subsequently, promotion to a more commensurate rank is still dependent on job performance and not solely on the position held. In general, reassignment of Commissioned Officers for permanent and temporary duty stations is more streamlined and requires the completion of markedly less administrative requirements. These aspects significantly contribute to a more flexible, diversified and mobile workforce that can better serve the needs of the Agency.

4. Emergency Response

   While civil servants can be mobilized in times of emergency, Commissioned Officers offer the national public health infrastructure increased flexibility in times of emergency. For example, Commissioned Officers are required to maintain readiness standards, can be ordered to report for duty to any situation, do not require overtime or compensatory time off when responding, can be more easily detailed to military units and cross-service task forces via identical personnel systems. One example of this flexibility is the past militarization of Commissioned officers assigned to the US Coast Guard. Additionally, all commissioned corps officers can be militarized as part of the United States Navy.

5. Physical Fitness

   All Commissioned Officers must meet mandatory physical fitness standards to maintain readiness status. In addition to allowing officers the physical capacity for all types of work in potentially challenging physical settings, CC officers complying with a physical fitness program are an example for how average citizens can incorporate physical activity in their daily routines, thus addressing the ongoing obesity epidemic.

The Commissioned Corps' Role in the Future of the Public's Health in the 21st Century

The Commissioned Corps, including CDC/ATSDR-assigned officers, is uniquely qualified to meet the needs outlined in the 2003 IOM report, as highlighted in Table 1 and listed above. They are uniquely qualified to accomplish these tasks by their intrinsic capacity (nurtured by Public Health Service regulations, culture and ideals) to bridge across the entire Department of

Health and Human Services as well as across all other Federal departments (especially, the Departments of Defense and Homeland Security) to establish programs, communicate ideas, and provide integrated public health capacity for the country.

However, in recent years some Commissioned Officers have been commissioned, trained, and mentored by a single agency resulting in a natural allegiance to the agency rather than the Public Health Service. This single issue greatly helps to explain the difficulty that some CDC/ATSDR Officers have had with endorsing the Commissioned Corps transformation. For example, the largest annual influx of Commissioned Officers has been through CDC's Epidemic Intelligence Service. Thus, the focus of the transformation on issues that do not appear to support the vital mission carried out at CDC/ATSDR have led to a dramatic reduction in the number of incoming EIS Officers who choose to enter the Commissioned Corps. A broader allegiance must be cultivated through positive measures. For example, the Commissioned Corps was transformed and re-invigorated in 1972 by the institution of the National Health Services Corps under legislation written and shepherded by Senator Warren G. Magnuson(6). To insure a successful contemporary transformation, similarly big ideas are needed to re-invigorate public health, the Public Health Service, and the Commissioned Corps. For example, ideas couched in the needs and context of today's public health and societal reality. Engaging Commissioned Officers as the leaders of a new, broadly defined public health mission that naturally crosses agency boundaries will result in a transformed Corps that meets the current needs of CDC/ATSDR and, ultimately, our society.

1. **Emergency Response:** The Commissioned Corps is unique in its ability to respond to the broad spectrum of public health emergency needs: clinical, regulatory, applied public health, administration, and research for prevention of future events. Transformation of the Commissioned Corps should capture all of these elements in establishing systems, training, force management, and recruitment and retention policies that explicitly address all of these capacities. To focus on solely on emergency clinical care, is short-sighted.

2. **A New Public Health Capacity:** The characteristics that differentiate the Commissioned Corps from the Civil Service provide the underpinnings for a unified, DHHS-wide public health capacity that provides strategies, programs and policies within the broad definition of public health created by the IOM in its landmark 2003 report. Transformation of the Commissioned Corps should include an exploration of the inherent flexibility of Corps structures to establish a new infrastructure for the Corps that includes joint appointments across agencies, visiting or exchange programs across agencies, joint training programs, and joint task forces to consult with and train state and local public health officials in the entire spectrum of public health activities. With Commissioned Officers at the helm of these efforts, the Corps and the entire Department will be transformed, increasing the capacity of each agency to perform its special functions, and enhancing the capacity of the entire Department to find new synergies that link all aspects of public health.

Conclusion and Recommendations

In 1965, Secretary John Gardner challenged the Public Health Service and its Commissioned Corps to set its sights high or risk becoming a footnote in history. The Public Health Service succeeded brilliantly, establishing new programs and infrastructure which have endured. The Commissioned Corps also evolved during that crucial time against the backdrop of the Vietnam conflict but without militarization. Rather, Commissioned Officers served the nation through efforts to eradicate Smallpox, reduce tobacco use, provide health care to migrant workers, increase childhood vaccination coverage, and augment military efforts through temporary duty assignments in South Vietnam to provide civilian health and sanitation support. Thus, "the national service rendered by the Corps, as well as its availability for military or civilian emergencies, was sufficient to maintain its historic status as a uniformed service"(7).

Today, transformation is occurring in the context of a new conflict: fighting the complex issue of world-wide terrorism. And, while transformation of the Commissioned Corps must take an improved response readiness into account – even with the possibility of militarization – it must also attend to transforming our ability to provide critical routine public health functions. By doing so, the officers of the Commissioned Corps will continue to render national service and be available for military or civilian emergencies, thus maintaining our historic status as a uniformed service and being re-invigorated in the process.

CDC/ATSDR-assigned officers are only one component of the Public Health Service Commissioned Corps, and provide critical applied public health expertise and service to the nation and the world, capacities that must be maintained. CDC/ATSDR-assigned officers can make immediate and meaningful contributions to the transformation of the Commissioned Corps and insure recognition of the vital role that public health practice plays in any crisis through the following recommended steps that can be implemented by the CDC Director/ATSDR Administrator:

Promoting Visibility and Leadership:

1. Establish an agency goal to increase the number of Commissioned Officers filling leadership positions at CDC/ATSDR (directors and deputy directors at the Division-, Center/Institute/Office-, Coordinating Center- and Office of the Director-levels).
2. Identify a CDC/ATSDR flag officer as the leader of the Commissioned Corps at CDC/ATSDR.
3. Respond immediately to requests for flag rank billet descriptions for all CDC/ATSDR leadership positions currently filled or targeted for flag officers; identify officers holding or selected for positions that hold or are requested to hold flag rank billets and provide supporting documentation for their immediate consideration for promotion to flag ranks.
4. Identify and nominate CDC/ATSDR-assigned Officers for vacant Chief Professional Officer positions.
5. Establish adequate funding to CDC's Office of Commissioned Corps personnel to provide adequate administrative and travel support for CDC/ATSDR-assigned officers serving as Chief Professional Officers or on category professional advisory committees, the Surgeon General's Policy Advisory Committee, and transformation work groups.
6. Establish a policy for daily wear of the Commissioned Corps uniform by all CDC/ATSDR-assigned Officers.

7. Establish an immediate policy for all CDC/ATSDR-assigned Officers to include their Commissioned Corps rank and affiliation on all papers, presentations, signature blocks, email signatures, CDC-wide email announcements, CDC Connects articles, and media interviews.
8. Establish a CDC/ATSDR COSTEP program to introduce students to the career and service opportunities provided by the Commissioned Corps at CDC.

Enhancing Emergency Response:

9. Facilitate 100% basic readiness qualifications for CDC/ATSDR officers through a series of training events, uniform clinics, and vaccination protocols.
10. Outline a comprehensive emergency response protocol that includes all public health functions: clinical, regulatory, applied public health, administration/policy-making, and research. Develop detailed recommendations for the applied public health and public health-related policy-making and research functions for emergency response.
11. Provide sufficient support to the CDC's Office of Terrorism Preparedness and Emergency Response to revise the Response Tracking System software to include Commissioned Officer response assignments and critical information elements.
12. Provide human and financial capital to the Commissioned Corps' Office of Force Readiness and Deployment to immediately establish updated tracking systems that link to CDC's OTPER-based systems for Officer responses.

Realizing a 21st Century Public Heath Capacity:

13. Establish and train teams of CDC-assigned Commissioned Officers for non-emergency deployments to state health departments to train, advise, and provide consultation services for newly appointed state health officers, other senior state health department officials, and CDC's newly appointed state-based Senior Management Officials/Portfolio Managers.
14. Urge the Secretary, Assistant Secretary for Health and Surgeon General to incorporate the important public health practice and research that occurs at CDC/ATSDR in meaningful ways in all transformation policies. For example, immediately finalize, approve and implement new officer groups (e.g., applied public health and clinical groups) similar to the Research Officer Group that complement and supplement the existing categorical structure, and include promotion criteria and deployment roles.
15. Urge the Secretary to recognize the contributions of Commissioned Officers throughout the American health system and to document those contributions throughout his 500-day plan, not just in the section on emergency preparedness and response.
16. Urge the Secretary, Assistant Secretary for Health and Surgeon General to explore opportunities for joint appointments, visiting or exchange programs, joint training, and inter-agency consulting teams of Commissioned Officers to establish a truly integrated public health capacity for the nation.

Optimizing Esprit de Corps:

17. Establish a highly visible annual Commissioned Corps promotion and award ceremony that is separate from the annual civil service award ceremony, open to all CDC/ATSDR staff, and presided over by the CDC/ATSDR Director/Administrator.
18. Sponsor and provide mentorship for a Leadership and Management Institute (LMI) team of officers selected from the CDC/ATSDR CCPAC to establish a strategic plan for maximizing Commissioned Officers' contributions to CDC/ATSDR.

19. Assure the availability of BOTC for all incoming officers within 6 months of their commission.
20. Establish a CDC/ATSDR-wide standard for award nominations and consideration under the new CDC organizational structure.
21. Educate civil service supervisors about the Commissioned Corps transformation, the added value of having Commissioned Corps staff on their teams, Commissioned Corps requirements including the importance of readiness, and special supervisory issues (e.g., awards and annual evaluations).
22. Urge the Secretary, Assistant Secretary for Health and Surgeon General to reconsider the promulgated promotion policies regarding the "three strikes and frozen" and "sixth precept" policies, taking into account an analysis of the effect these policies have had on promotion rates, retention, recruitment, and morale.

A note on the recommendations:

The twenty-two recommendations above provide a package of low-cost actions that can be taken immediately to begin to heighten awareness of Commissioned Corps transformation issues throughout the Agency and to demonstrate broad commitment to the continued success of Commissioned Officers at CDC and ATSDR. They can largely be operationalized through CDC/ATSDR's Office of Commissioned Corps personnel and the CDC/ATSDR Commissioned Corps Policy Advisory Committee. Excepting recommendations 14, 15, 16, and 22, these actions can be taken by the CDC/ATSDR Director and officers independently of DHHS; in discussions with the Secretary, Assistant Secretary for Health, or Surgeon General they can be reworded as commitments made by the CDC/ATSDR Director that demonstrate her support of the Commissioned Corps and allow her greater visibility on these and other issues.

In addition, it should be noted that the first recommendation is set as a goal, not a mandate. Such a goal not only provides a visible commitment to the Commissioned Corps by the CDC/ATSDR Director, but establishes a demand and supply chain for Commissioned Officers. A periodic review of leadership positions held by Commissioned Officers and Civil Servants should occur on at least a triennial basis in conjunction with the CDC Office of Commissioned Corps Personnel. By regularly evaluating the proportion of leadership positions at CDC/ATSDR held by Commissioned Officers, the agency can begin to determine whether officers are available and whether they are being sufficiently trained and mentored to move into these leadership positions. This goal will help to insure the placement of capable, trained and motivated Commissioned Corps Officers in leadership positions at CDC/ATSDR to not only serve the Agency, but to also represent the interests of Commissioned Officers at CDC/ATSDR.

Table 1. Characteristics of Commissioned Officers and Civil Servants

Difference	Commissioned Officers (CO)	Civil Servants (CS)
Duty Hours	Work: **40** hours/week On-Call: **24/7**; mandatory	Work: **40** hours/week On-Call: **Variable**; optional
Ease of Reassignment	More ***flexible*** re-assignment ability (temporary and permanent) compared to civil service	Process of reassignment, especially permanent, can be much ***lengthier*** due to administrative requirements
Skill Diversity/ Depth of Knowledge	Advancement criteria in PHS is partly based on **mobility**; CO often make several **geographic and programmatic moves** during their career, thereby broadening skill diversity, which benefits Agency	Choice to move, often is dependent only on **initiative of the individual** versus the need of the Agency. Advancement in CS system has less emphasis on such moves
Deployability and Readiness	**Mandatory** obligation to be prepared for deployment and mandatory readiness requirements for a pre-selected deployment role; CO can be **militarized** by Presidential Executive Order	Deployment readiness is usually **optional**, up to the individual and for many CS positions, not relevant
Physical Fitness	**Mandatory** physical fitness requirements currently being phased in	**No** physical fitness requirements
Visibility	Uniform **immediately** distinguishes a commissioned officer from a civil servant to the public	**Indistinguishable** from any other civil servant to the public
Licensure	**Mandatory** requirement to maintain licensure	**Optional** licensure maintenance
Clinical Skills	**Mandatory** maintenance of clinical skills to receive special pays for selected categories (e.g., physicians)	**No** work-related incentive to maintain clinical skills even if potential benefit for Agency and Department; Special pays often used as compensation **without requirements** such as maintenance of clinical skills for selected positions
Operation	CO expected to function in a **higher level of responsibility** (e.g., billet) prior to actual promotion to a rank commensurate with those duties	CS **may not** permanently occupy a position graded higher than their current grade (may be paid at the higher level during a detail)
Retention	CO must remain in active duty for 20 years to receive retirement benefits	CS vested in retirement benefits after 3 years.

Table 2. Benefits of Commissioned Officers to CDC/ATSDR and DHHS

Characteristics	Benefit
Duty Hours	• Increased availability of officers • **No overtime pay** or compensation • More **focus on the job** than on "hours worked"
Ease of Reassignment	• ***Increased flexibility*** for personnel management
Skill Diversity/ Depth of Knowledge	• Culture of "encouraged moves" broadens overall **depth of knowledge** and skill sets of CO, which benefits Agency
Deployability and Readiness	• **Mandatory** responsibility to be ready for deployment 24/7 if needed
Physical Fitness	• Commitment to healthy lifestyle • Commitment to **"practicing what is preached"**
Visibility	• **Immediately** recognizable to public • Uniform automatically instills ideals of duty, competence, and authority • **Unique and underutilized** route of communication for Agency to deliver messages to public and medical community
Licensure	• **Licensed personnel** (when applicable) available for Agency missions and needs
Clinical Skills	• Bridges gap between clinical medicine and public health • Maintenance of skills, facilitates **credibility** among clinical practitioners • Enables optimization of public health practice by **practical experience and application** • CO practicing clinical medicine must maintain their continuing medical education, which maintains **knowledge base** of clinical advances and current clinical issues of importance
Operation	• Enables **efficient** management of capable personnel • Increased **flexibility** with filling positions • Promotion still dependent on **job performance**
Retention	• Ensures highly skilled public health professionals will be available to achieve agency missions

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